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FINAL REPORT
DEVELOPMENTAL DISABILITIES STUDY

As Required By

HOUSE JOINT RESOLUTION NUMBER 26
OF THE 47TH LEGISLATURE

LEGISLATIVE FINANCE COMMITTEE

Helena, Montana
January, 1983

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Members of the 48th Legislature:

This is the final report on the study of services to the developmentally disabled. It is presented in compliance with House Joint Resolution Number Twenty-six of the 47th Legislature. The study has documented that the delivery of services to the developmentally disabled is efficient and that the current state administrative structure is working. However, this does not mean that the delivery system does not have problems. A major problem is the relationship between SRS and the DD providers. This report has outlined the problems and should be useful to you in your deliberations during session to improve the delivery of services to the developmentally disabled.

Senator Ed B. Smith, Chairman
Legislative Finance Committee

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FINAL REPORT

DEVELOPMENTAL DISABILITIES STUDY

As Required By

HOUSE JOINT RESOLUTION NUMBER 26

OF THE 47TH LEGISLATURE

LEGISLATIVE FINANCE COMMITTEE

Helena, Montana

January, 1983

PREFACE

This report documents the findings of the Legislative Finance Committee in its study of services to developmentally disabled persons. The study is the result of legislative concern expressed through House Joint Resolution Twenty-Six of the Forty-Seventh Legislature.

The Legislative Finance Committee is a twelve-member, bipartisan, joint committee of the Senate and the House of Representatives. It was created in 1975 as a permanent committee to oversee, study, and review financial matters of the state that are relevant to issues of policy and statewide importance. The committee appoints and employs the Legislative Fiscal Analyst who provides staff support for the committee. At least eight of twelve members of the Legislative Finance Committee are selected from appropriation committees of the Legislature.

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INTRODUCTION

The 1981 Legislature passed HJR 26 which directed the Legislative Finance Committee to study:

1. the extent of the need for services to youth, the developmentally disabled, the mentally ill, and the drug dependent;

2. the effectiveness of institutional programs and of community-based programs for persons in each of these groups;

3. the cost of treatment within institutions and within community-based services;

4. the effect on the employees of institutions and of community-based services of any changes recommended;

5. alternatives to the existing administrative structure which would provide better service to each group, including combining certain functions within one department or combining some services into regional centers;

6. the relationship of community private, nonprofit service corporations to the state and ways to clarify duties and responsibilities; and

7. alternative financing mechanisms which would allow for the most appropriate treatment to the individual, whether in the institutions or in the community.

The resolution came about due to deinstitutionalization, controversy over the merits of institutions versus community care, and the need to provide services which are most beneficial to the recipients through economical methods.

At its August 1981 meeting, the committee decided to concentrate on the resolution as it relates to developmentally disabled (DD) persons. This report examines the effectiveness of the DD system, need for DD services, cost of DD services, state administrative structure, relationship of nonprofit provider corporations to the state, and problems in the present system. The section below describes the services offered in the community and in the institution.

Community and Institutional Programs

Community-based programs include residential, vocational, transportation, family training, respite, and special education services. Residential services range from intensive group homes for adults with very low self-help skills or serious maladaptive behaviors to semi-independent support which provides follow-along care for clients who live in their own apartments. Other residential services are children's group homes, adult group homes, foster care, and supervised semi-independent living (an intermediate step between a group home and semi-independent living).

Vocational training ranges from developmental centers for teaching prevocational skills to work activity centers to sheltered workshops for higher functioning clients. In addition, day programs for elderly DD persons are offered which are not vocationally oriented. The elderly day programs offer group activities (field trips, cooking, hobbies) to the older DD persons.

Transportation services take DD persons from the group home to the day services and other activities.

Family training corporations teach families to train their DD children. These corporations also provide information and referral services and resources and support for families with DD children.

Respite services provide brief periods of relief for parents with a DD child (youth or adult). Parents are reimbursed up to $360 a year for sitter services provided by a trained person.

By law, special education services are available to all DD children aged 6 to 18. In addition, many school districts have programs to serve DD children aged 3 to 5 and 18 to 21.

Institutional Programs

Boulder River School and Hospital (BRS&H) and Eastmont both offer training to DD residents. On the staff at BRS&H are physical therapists, occupational therapists, speech therapists, medical doctors, and special education teachers. Six hours of education per day are provided to each child under age 22. Adults receive daily training also, but usually it is less than six hours. Residents of Eastmont receive six hours of training daily. Some of Eastmont's professional services (psychiatric, medical) are performed on a contract basis rather than by employees of the institution.

I. EFFECTIVENESS OF SERVICES

This section looks at the definition of effectiveness and how effectiveness can be measured.

Definition of Effectiveness

The staff asked SRS, the Department of Institutions, members of the DD Planning and Advisory Council, and DD providers (nonprofit corporations) how they would define "effectiveness". Responses included "cost effective", "relative happiness of clients",. "normalization", "meeting contract goals", and "living in the least restrictive environment."

Since there was no general agreement as to how to define effectiveness, the staff looked at the legal mandate which applies to both institutional and community-based facilities. According to 53-20-101, MCA, the purpose of the developmental disabilities legislation is to:

"1) secure for each person who may be developmentally disabled such treatment and habilitation as will be suited to the needs of the person and to assure that such treatment and habilitation are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

2) accomplish this goal whenever possible in a community based setting;

3) accomplish this goal in an institutionalized setting only when less restrictive alternatives are unavailable or inadequate and only when a person is so severely disabled as to require institutionalized care; and

4) assure that due process of law is accorded any person coming under the provisions of this part."

The mandate is further refined in 53-20-148(2), MCA, which specifically relates to residential facilities and states:

"2. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the facility shall make every attempt to move residents from:

a) more to less structured living;
b) larger to smaller facilities;
c) larger to smaller living units;
d) group to individual residence;
e) segregated from the community to integrated into the community living;
f) dependent to independent living."

It is clear from this legislation that the intent of the legal mandate is to provide the most appropriate treatment of developmentally disabled individuals, in the community whenever possible and in a manner that meets their needs and respects their personal dignity.

Measurement of Effectiveness

Measuring the effectiveness of the legal mandate to meet persons' needs in the least restrictive environment in the manner which respects their dignity can be pursued in many ways. This report reviews client movement through the system by showing the progress towards less restrictive environments and provides the opportunity to hear from people interested in the DD system on how DD persons' lives have changed as they are moved to less restrictive environments.

Client Movement - Institution to Community

Tracking client movement through the system is one method of measuring the effectiveness of the system. Table 1 shows the number of DD persons who have been deinstitutionalized since April 1975.

Table 1
Number of DD Placements
From Institutions to the Community
April 1975 to Present

Institution	4/1/75 to 7/1/77	7/1/77 to 7/1/79	7/1/79 to 7/1/81	7/1/81 to Present	Total
BRS&H - Children	46	25	6	0	77
BRS&H - Adults	169	22	38	1	230
Galen	30	3	0	0	33
Warm Springs	35	13	15	2	65
Eastmont	0	0	3	1	4
Total	280	63	62	4	409

During this period, BRS&H dropped in population from 400 residents to 222. While 307 residents moved from BRS&H to the community, a number of DD persons moved from Warm Springs to BRS&H. In addition, a significant number of DD persons moved from nursing homes to the community.

Because the emphasis from the last legislature was on servicing DD persons already in the community, only four persons have been deinstitutionalized in the past year. BRS&H officials indicate that about eight of the current 222 residents could be placed in existing, nonintensive community services if space were available. The Department of Institutions is working with SRS to determine how many residents could be placed in intensive group homes. That study will be completed later this summer.

Client Movement - Within Community Services

Table 2 shows the movement of DD persons to and from semi-independent living. Services were expanded during this time so that 106 new DD persons received semi-independent living services. Eighty-four

persons moved out of semi-independent living. A total of 161 DD persons were being served at the end of December 1981.

Table 2
Movement to and from Semi-Independent Living Services
July 1980 Through December 1981

Persons Served--July 1, 1980		139
Persons Who Entered the System	106	
Persons Who Left the System	(84)	
Increase in Persons Served		22
Number of DD Persons Served--December 31, 1981		161

Table 3 looks at the movement from semi-independent living. A total of 84 persons moved out of semi-independent living services in the 18-month period from July 1980 to December 1981. Thirty-five of these people moved to independent living, a less restrictive environment. Thirty-seven persons moved to other places. Generally, movement from semi-independent living to a group home is considered more restrictive, but not always. Sometimes a person receives semi-independent training while living at home. He then might move to a group home, a less restrictive environment. On the other hand, a person in semi-independent living in the community might move back to a group home, a more restrictive environment.

Table 3
Where DD Persons Moved When They Left Semi-Independent Living
July 1980 Through December 1981

Placed Moved To	Number of DD Persons
Independent Living	35
Group Home	10
Family Home	17
Foster Home	5
Nursing Home	4
Institution	1
Other	12
Total	84

Table 4 shows the movement of DD persons in and out of adult group homes. A number of people moved from group homes to semi-independent living, but a significant number went to nursing homes. Since many nursing homes do not have specialized programs for DD persons, this placement is not encouraged because it is more restrictive. DD persons may move to nursing homes because of age, medical conditions, or inability to live in a group home.

Table 4
Movement to and from Adult Group Homes
July 1980 Through December 1981

Persons Served--July 1, 1980		368
Persons Who Entered Group Homes		119
Persons Who Moved Out of Group Homes	(64)	
Increase of Persons Served		55
Persons Served--December 31, 1981		423

During the period July 1980 through December 1981, 119 DD persons moved into group homes. The above table shows 64 persons moving out of

group homes, resulting in a net increase of 55 DD persons served. Thus, the total number of DD persons served in adult group homes in December 1981 was 423.

Table 5
Where DD Persons Moved When They Left Group Homes
July 1980 Through December 1981

Placed Moved To	Number of DD Persons
Semi-Independent Living	15
Family Home	10
Foster Home	6
Other DD Home	1
Nursing Home	14
Deceased	2
Other	16
Total	64

The above tables show that a total of 64 DD persons moved out of adult group homes during the period July 1980 through December 1981. Fifteen of these persons moved to semi-independent living, a less restrictive environment. In December 1981, a new option was introduced--supervised semi-independent living. This option is an intermediate step for the abrupt change between a group home and semi-independent living.

Because of the limited number of slots to move into, the above tables do not necessarily reflect the potential movement. For example, if more semi-independent slots were available, more DD persons may have been able to move from group homes.

Change in Quality of Life

Another measurement of effectiveness of the DD system is the improvement (or lack of improvement) in the quality of life of the DD individual.

Areas which may be examined include level of dependency, vocational achievements, social interaction, academic achievements, personality growth, and community integration. Many of these areas are subjectively evaluated. Providers, representatives of the institutions and SRS, family members of DD persons, and other interested persons attended a Legislative Finance Committee meeting to express their views about the effectiveness of the DD system.

Summary

In this report, "effectiveness" is defined as compliance with the legal mandate, which addresses the idea of DD persons living in the least restrictive environment in which services can be received to meet their needs. Effectiveness is measured by looking at movement through the system and by looking at the personal growth of DD individuals. Considerable movements has taken place from institutions to the community. Within the community, movement is in both directions--to more restrictive and to less restrictive environments. In addition, public testimony was received about the changes in personal growth and happiness due to moving persons to the least restrictive environment which meets their needs.

II. NEED FOR SERVICES

The need for DD services can be demonstrated by the number of people currently receiving services and the number of people waiting for openings to services. The following table shows the number of community services DD persons are receiving and the number of community services DD persons are waiting for.

Table 6
Current Service Slots Needed
December 1981

Service	Service Slots Available	Service Slots Unduplicated Waiting List	Service Slots Total Needed
Childrens Group Home	46	41	87
Adult Group Home	423	233	656
Day Services	985	267	1,252
Transportation	911	267	1,178
Semi-Indep. Support	161	101	262
Family Training	404	66	470
Respite	361	45	406
Total Service Slots	3,291	1,020	4,311

As shown in the table, 3,291 service slots now exist and an additional 1,020 slots are needed. Currently, 1,689 persons are being served in the 3,291 service slots, and 651 persons are on the waiting list for 1,119 services. There is some overlap between those currently being served and those on the waiting list. As of December 1981, there were 99 duplicated slots. This happens, for example, if someone in a group home is on the waiting list for semi-independent living. When he moves into semi-independent living, a group home spot opens.

The waiting list in Table 6 includes 61 persons who will graduate from special education in 1982 and will be in need of services in fiscal 1983. It does not include 93 persons who will graduate from special education in 1983 and 1984. Those persons who graduate in 1983 will need service beginning in fiscal 1984.

Also not included on the waiting list are the eight BRS&H residents and the three residents from Eastmont whom the institutions believe could be placed in existing non-intensive services if space were available. Since no money is available this biennium for deinstitutionalization, SRS does not carry these people on its waiting list.

As more people become aware of DD services, the waiting list expands. The waiting list increased from 558 persons (including all known special education students) in September 1981 to 703 persons (including all known special education students) in December 1981.

The 1981 Legislature appropriated $1,885,163 for the 1983 biennium to expand community services for developmentally disabled persons. The following table shows the existing service slots, and the type and amount of expanded services which will be developed with these funds.

Table 7
Number of Service Slots Available by End of
1983 Biennium

Service	Service Slots Available Before Expansion	Expansion Slots	Total Service Slots Available by July 1, 1983
Children's Group Home	46	4	50
Adult Group Home	391	72	463
Day Services	964	166	1,130
Transportation	911	166	1,077
Semi-Independent Support	161	58	219
Family Training	404	15	419
Respite	361	0	361
Total	3,238	481	3,719

The above table shows that 481 new service slots will be added with the expansion money. However, more service slots will be needed for the 1985 biennium. The table below looks at service slots needed in 1985.

Table 8
Service Slots Needed in 1985 Biennium

Service	Service Slots Needed Currently	Special Education Graduates	BRS&H and Eastmont Deinstitution.	Total Service Slots Needed by 1985
Children's Group Home	87	0	0	87
Adult Group Home	656	41	11	708
Day Services	1,252	82	11	1,345
Transportation	1,178	82	11	1,271
Semi-Independent Support	262	12	0	274
Family Training	470	0	0	470
Respite	406	0	0	406
Total	4,311	217	33	4,561

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By the end of fiscal 1985, 4,561 service slots will be needed. This includes special education graduates in 1983 and 1984 and the deinstitutionalization of 11 persons from the institutions.

Table 9
Comparison of Service Slots Available
and Service Slots Needed by
1985 Biennium

Service	Service Slots Needed	Service Slots Available	New Slots Needed
Childrens Group Home	87	50	37
Adult Group Home	708	463	245
Day Services	1,345	1,130	215
Transportation	1,271	1,077	194
Semi-Indep. Support	274	219	55
Family Training	470	419	51
Respite	406	361	45
Total	4,561	3,719	842

Table 9 shows that 3,719 slots will be available at the beginning of the 1985 biennium and 4,561 service slots will be needed.

Thus, the total number of new service slots needed during the 1985 biennium is approximately 842. Two hundred forty-five additional group home slots, 215 day-service slots and 37 children's group home slots will be needed. Factors which make these numbers approximations are the unknown variables of the amount of movement through the system and the number of special education graduates. When examining the above tables the following factors should be considered:

1. No allowance has been made for attrition or movement through the system. The current duplication on the waiting list has been considered. However, one goal of the DD system is to move people through the system.

Movement other than this known duplication has not been considered. This factor will overstate the number of service slots needed.

2. The number of special education graduates in understated. For example, Region V, which includes Missoula and Kalispell, reports only five special education graduates in their waiting list for June 1983 and none for June 1984.

3. The amount of movement of unknown persons into the system has not been approximated. Family training, which primarily serves children birth to age six, would be affected by these people. The current "baby boom" and the phasing out of some preschool programs for DD children may impact the waiting list for family training programs.

4. BRS&H and Eastmont estimate 11 residents could move into existing (nonintensive) services in the community. More residents would be able to move if intensive group homes and group homes for behavior problems were included.

5. Other institutionalized DD persons could be moved into the community if more intensive group homes were available. Currently, SRS is contracting for two intensive group homes, both of which began providing services in December 1981. The Department of Institutions and SRS are working on a proposal to deinstitutionalize more DD persons from BRS&H and Eastmont using funds from the Medicaid waiver. The Medicaid Waiver is discussed on Page 22.

III. COST OF SERVICES

This section examines the cost of providing services to DD individuals. The total cost of providing services in the community is compared to the cost of providing services in an institution.

Cost of Community-Based Services

Community services are funded through many sources. One of the main sources is the DD Division in SRS. This subsection looks at the unit of service definition, the cost to the DD Division, the other funding sources used by providers, the miscellaneous costs, and the total cost for providing community services.

Unit of Service Definition

The amount of service provided is measured in units. The definition for a unit of each type of service is shown in Table 10.

Table 10
Unit of Service Definition

Type of Service	Definition of Unit
Community Homes	A unit of service for children and adult community homes shall be considered as one day in which the client is present in the community home and receiving training.
Day Services	A unit of service for day services shall be considered as one day in which the client was in attendance for at least six hours.
Family and Child Training	A unit of service for family and child services is training for one child and his family per month.
Respite	A unit of service for respite services is services provided for one person and his family per year.
Semi-Independent Living and Training	A unit of service for semi-independent living and training services is services provided to one client per month.
Transportation	A unit of service for transportation is one ride per client from point A to point B.

Costs to the DD Division

Some types of services (transportation, respite, semi-independent living) are funded almost entirely by the DD Division. Other services, such as group homes, have many sources of funds. The table below shows the cost to the DD Division of providing each type of service.

Table 11
Community Services Cost to DD Division
Fiscal 1981

Type of Service	Cost	# of Units of Service	Cost Per Unit
Children's Group Home	$ 540,427	15,518	$ 34.83
Adult Group Home	1,286,287	133,318	9.65
Day Services	4,248,436	213,577	19.89
Transportation	566,471	430,730	1.32
Semi-Independent Living	333,438	1,731	192.63
Family Training	801,348	4,031	198.80
Respite	190,607	491	388.20
Evaluation & Diagnosis	171,623	115	1,492.37
Adaptive Equipment	39,197	146	268.47
Grants	126,479	N/A	N/A
Incentive Payments	1,968	N/A	N/A
Total Cost	$8,306,281		

Grants are made for one time expenditures--down payments on group homes, large equipment purchases, etc. Incentive payments are funds given to a group home to hold a slot open for up to 30 days for a DD person who has moved to semi-independent living. Since the DD person is not residing in the group home, the group home does not receive SSI payments from him. The group home holds the DD person's slot in case the semi-independent living arrangement does not work out; otherwise the DD person would have nowhere to go.

Other Funding Sources

To determine the amount of other funding sources, a questionnaire was sent to all DD providers. The questionnaire asked the providers to list all sources of income for fiscal years 1980 and 1981. Sources of income include funds from the contract with the DD Division, Supplemental Security

Income (SSI), Social Security payments, private donations, local funds, food stamps, low income energy assistance payments, commodity programs, vocational rehabilitation funds and production income. In addition, many community services use volunteers and programs such as foster grandparents, a federally supported program which pays "grandparents" $2 per hour for 20 hours of work each week. Medicaid and special education costs were addressed separately.

Forty of the 59 providers responded to the survey. After the responses were received, they were compiled and sent back to the providers for verification. The accuracy of some responses appears questionable. For example, 9 of the 26 active adult group home providers showed that they received no SSI payments. Since all adult group homes receive SSI payments, some of the information is incorrect.

Based on survey responses, the following table shows the percentage of the total funding contributed by each funding source.

Table 12
Percentage of Total Funds Contributed
by each Funding Source

Funding Source	Children's Group Home	Adult Group Home	Day Services	Trans.	Semi-Independent Support	Family Training	Respite
DDD	71.5	45.2	81.0	100	88.0	98.1	100
SSI	22.0	51.8	---	---	---	---	---
Commodities	0.2	.5	---	---	---	---	---
Food Stamps	1.0	1.4	---	---	---	---	---
Low Income Energy	.2	.9	---	---	---	---	---
Local Funds	---	.2	---	---	4.1	---	---
CETA	3.4	---	---	---	---	---	---
Production	---	---	17.0	---	---	---	---
Other	1.7	---	2.0	---	7.9	1.9	---
Total	100	100	100	100	100	100	100

If responding providers are representative of all providers, some services are funded significantly by sources other than the DD Division. However, state and federal funds account for almost all of the funding of DD services.

SSI is a welfare program run by the federal government. SSI funds are intended for client room and board (DDD funds are generally for training). The state supplements the SSI amount. Each eligible client receives both the basic SSI benefit amount plus the state supplement in a single monthly check. Out of the check, the client receives personal needs money which is currently $40 per month. The group home provider receives the remainder. The amount of the monthly check is shown in the following table.

Table 13
SSI Amounts
Fiscal 1980 through Fiscal 1982

	FY 1980	FY 1981	FY 1982
SSI Benefit	208.20	238.00	264.70
State Supplement	104.00	104.00	104.00
Total	312.20	342.00	368.70

If a client has other sources of income (social security based on a parent's work, retirement, his own work), an adjustment is made to the amount of SSI received. In Table 12, SSI includes income received for room and board from other sources (social security, job, etc.). SSI is a significant source of income to group home providers. During fiscal 1981, SSI funds accounted for 51.8 percent of the total group home funding.

Most group homes participate in the food stamps and commodities programs. According to SRS, 56 out of 65 group homes were receiving food stamps in April 1982 . However, survey responses indicate that only 11 out of 28 group home providers used food stamps in fiscal 1981. SRS figures also indicate that 55 out of 65 group homes use the commodities or school lunch program as of April (five additional group homes have applied for the commodities program). According to the responses from providers, food stamps and commodities account for between 1 and 2 percent of their group home funding.

Group homes were allowed to participate in the low income energy assistance program in fiscal 1980 and 1981, but in fiscal 1982, they were determined to be not eligible. Responding providers indicated that the low income energy program accounted for less than 1 percent of their funding.

Production income amounted to about 17 percent of the day services income. This funding is generally used to buy new materials for production and for salaries. Some day programs do not have production income, others receive more in production income than they receive from the DD Division. Providers estimate that production income should be about half of the funding for the day services. However, this report uses the amounts listed by providers in their survey responses.

Some sources of income were not included in this summary. Many providers did not report vocational rehabilitation money, because they could not separate the money received for DD clients from the money received for other clients. However, only a few DD clients are eligible for vocational rehabilitation services. Donated goods are not included in the totals. Many providers reported these, others said they were "considerable." The cost of foster grandparents, which is paid by the federal government, also has not been included.

Another source of funds became available this fiscal year--the Medicaid Waiver. Medicaid will pay for a DD person in an institution or a nursing home to move to a community setting if the community setting costs less than institutionalization and meets the client's needs. Four group homes serving 32 DD clients currently receive Medicaid per diem reimbursement. SRS and the Department of Institutions are looking into using this source of funds for other group homes.

Based on the percentage of non-DDD funds received by responding providers, the total cost for all providers was calculated. In Table 14, the "Percent of Funding from the DD Division" came from Table 12. The "Amount of Funding from the DD Division" and "Number of Units Provided" came from Table 11. By dividing the "Amount of Funding from the DD Division" by the "Percent of Funding from the DD Division", the "Extrapolated Funding Received from All Sources" was calculated. Table 14 then shows the total cost per unit of service for each type of service. Some units represent daily costs; others represent yearly costs.

Table 14
Cost Per Unit of Service for Community Services
Fiscal 1981

Service	Percent of Funding from DD Division	Amount of Funding from DD Division	Extrapolated Funding received from All Sources	Number of Units of Service Provided	Cost Pe Unit of Service
Children's Group Home	71.5	$ 540,427	$ 755,842	15,518	$ 48.71
Adult Group Home	45.2	1,286,287	2,845,768	133,318	21.35
Day Services	81.0	4,248,436	5,244,983	213,577	24.56
Transportation	100	566,471	566,471	430,730	1.32
Semi-Independent	88.0	333,438	378,907	1,731	218.90
Family Training	98.1	801,348	816,869	4,031	202.65
Respite	100	190,607	190,607	491	388.20
Total		$7,967,014	$10,799,447		

Table 14 shows that the DD Division contributed $7,967,014 of the approximate total funding of $10,799,447. Thus, approximately 74 percent of the funding for the above services came from the DD Division.

The following table looks at the number of units of service utilized by a DD person and calculates the cost of service for a year.

Table 15
Cost Per Year for Each Service
Fiscal 1981

Service	Typical Number of Units in One Year	Cost Per Unit	Cost Per Year
Children's Group Home	365	$ 48.71	$17,779
Adult Group Home	365	21.35	7,793
Day Services	250	24.56	6,140
Transportation	500	1.32	660
Semi-Independent	12	218.90	2,627
Family Training	12	202.65	2,432
Respite	1	388.20	388

Miscellaneous Costs

Other costs may be attributed to serving DD persons in the community. This section describes the costs of Medicaid, special education, social workers (who are case managers) and DD Division administration.

Medicaid--Most DD persons are eligible for Medicaid. SRS estimates the average Medicaid cost per DD person was $2,700 in fiscal 1981.

Special Education--Total special education costs for DD persons in fiscal 1981 were conservatively estimated by OPI to be $5.2 million. Based on 1,850 mentally retarded students in special education, the cost per student was $2,811.

Social Workers--Each DD person is assigned to a county social worker who acts as a case manager. Based on an SRS study which shows social

workers spent 17 percent of their time with DD clients, a conservative estimate for the cost of social workers would be $579,854. This figure includes only personal services costs. Based on 1,030 adult DD persons in fiscal 1981, the cost per person is $563.

DD Division Administration--In fiscal 1981, the DD Division administration costs were $1,089,501. Based on 1609 DD persons in fiscal 1981, the cost per person is $677.

Total Costs

The total cost for providing services to a DD person in the community is composed of many parts. A typical combination of services for an adult in the community consists of group home, transportation, and day services. To these costs, the cost of Medicaid, case management and DD Division administration must be added. Table 16 indicates that the total cost associated with a DD adult living in a group home is approximately $18,533.

Table 16
Cost of Community Services for DD Adult in Group Home
Fiscal 1981

Type of Service	Cost
Group Home	$ 7,793
Transportation	660
Day Service	6,140
Medicaid	2,700
Case Management	563
DDD Administration	677
Total Cost	$18,533

The table below displays the total cost of providing services to a DD child who lives in a group home. The group home, education, medical, and administrative costs are considered.

Table 17
Cost of Community Services for DD Child in Group Home
Fiscal 1981

Type of Service	Cost
Group Home	$17,779
Special Education	2,811
Medicaid	2,700
DDD Administration	677
Total Cost	$23,967

The total cost of providing services for a group home child is approximately $23,967.

Cost of Institutional Service

Two institutions, BRS&H and Eastmont, provide residential services for DD persons. The cost of providing this service is paid almost entirely by the federal and state governments. State law requires a person in a state institution to pay if he is able or if he has insurance coverage.

Medicare and private insurance companies pay medical related costs at BRS&H. Since BRS&H is an intermediate care facility (as opposed to a skilled nuring care facility), per diem costs are not paid by Medicare and insurance companies. However, Medicaid pays room and board costs for those persons eligible for Medicaid. Currently, 204 persons at BRS&H are eligible for Medicaid.

Eastmont receives reimbursements from private resources and from Medicaid. Persons in the five-day program at Eastmont are considered educational placements and thus are not eligible for Medicaid reimbursement

for room and board. Since Eastmont contracts out for its medical services, those physicians bill Medicaid, insurance companies, and Medicare directly.

Table 18 shows total expenditures at each of these facilities for fiscal 1981. The private and insurance payments are deducted, which shows that federal and state dollars paid $8,857,401 at Boulder and $1,408,940 at Eastmont for fiscal 1981.

Table 18
Total Costs Incurred at Boulder and Eastmont
Fiscal 1981

	Boulder	Eastmont
Total Cost	$8,974,164	$1,428,273
Private & Insurance	116,763	19,333
State & Federal Cost	$8,857,401	$1,408,940

The cost for medical treatment is not included in Eastmont's budget. If a resident requires medical treatment, he is treated by an outside physician who bills Medicaid directly. Some medical costs are not included in BRS&H's budget. When a resident requires treatment by an outside physician or when he requires hospitalization in an outside hospital, his costs are billed directly to Medicaid. SRS did not have an estimate of the additional cost of Medicaid for the institutional residents.

Based on an average daily population of 229.92, the cost in state and federal funds per BRS&H resident was $38,524 in fiscal 1981. The cost per resident at BRS&H is high for many reasons. First, the cost includes medical care. Many residents at BRS&H have severe medical problems. BRS&H operates a small hospital to care for these people. Another reason for the high cost is the physical plant. The facilities which once housed

cost fo 1,000 residents are not efficient for the current 220 residents. Some of the buildings utilized are old. Also, the institution feels the heating system is not efficient. In January, 1982, the natural gas bill for BRS&H was over $50,000 or approximately $220 per resident.

The cost per resident of providing care at Eastmont is more difficult to measure. Eastmont has both a five-day program and a seven-day program. During fiscal 1981, the five-day program averaged 15.4 students, and the seven day program averaged 38.9 students. The five-day program serves children whose school districts do not provide appropriate special education programs. These students attend Eastmont during the week and return home on weekends. The children are considered "educational" placements as opposed to "institutional" placements. They are not charged for room and board nor is their daily cost paid by Medicaid. Residents in the seven-day program are committed by a court. They are eligible for Medicaid daily reimbursement because Eastmont is an ICF/MR facility.

Since Eastmont does not provide medical treatment, the costs are not comparable to BRS&H which has a small hospital. One way to calculate the of the seven-day program is to look at the Medicaid reimbursement rate which applies only to the seven-day program and add an average cost for the services not reimbursed by Medicaid. Examples of costs not reimbursed are hair care, meals for the foster grandparents, and education for the residents.

The following chart shows the cost per resident at Eastmont.

Table 19
Eastmont Costs--Seven-Day Program
Fiscal 1981

	Eastmont
Daily Rate per Resident Allowed by Medicaid	$ 56.60
Total Rate per Resident for Fiscal Year	$20,659
Cost per Resident for Education	3,973
Cost per Resident Without Medical Costs	$24,632

The total cost per resident in the seven-day program is approximately $25,000. However, this cost does not include the cost of any medical treatment. Eastmont does not have physicians on its staff. When a resident needs medical treatment, the doctor bills Medicaid directly.

The above discussion indicates that the cost (in government funds) of keeping a person in an institution is between $25,000 and $39,000. The $25,000 cost at Eastmont does not include the cost of medical care. The $39,000 cost at BRS&H includes medical care provided by BRS&H but not treatment by an outside physician.

Summary

The cost of providing group home and related services to an adult in the community was approximately $19,000 in fiscal 1981 with medical care. A child in a group home cost about $24,000 with medical care. During this time, the state and federal government paid approximately $39,000 to maintain a resident in BRS&H with some medical care and $25,000 to maintain a resident in Eastmont without medical care. Unlike the community-based services, the cost of adding or deleting a resident at an institution is not the average unit cost. Also, neither the institutional cost nor the community cost recognizes major building construction and upkeep.

IV. STATE ADMINISTRATIVE STRUCTURE

This section looks at the four state agencies involved in providing services to DD individuals. The first subsection describes the function of each agency. Then the second part discusses problems with the present administrative structure.

Functions of State Agencies

Currently, four departments are involved in providing services for developmentally disabled persons: Department of Social and Rehabilitative Services, Department of Institutions, Office of Public Instruction and Department of Health and Environmental Science. The function of each of these departments is described below.

1. Department of Social and Rehabilitative Services.

Four divisions in SRS provide services to DD persons (all of these divisions except the DD Division also provide services to other needy individuals):

A. Developmental Disabilities Division--This division establishes and maintains specialized community based services for DD persons. Through contracts with nonprofit corporations, the DD Division provides services including residential, day activity, transportation, respite, and diagnosis and evaluation. In addition, the division provides case management services to DD individuals released from an institution into a community program prior to their formal discharge from the institution.

B. Community Services Division--Through its network of county social workers, the Community Services Division provides case management services to DD persons. Each developmentally disabled adult is assigned a case manager who is responsible for coordinating both the Individual Habilitation Planning (IHP) team meetings and the provision of services as outlined in the IHP. In addition, the division provides for foster care for 26 DD persons.

C. Economic Assistance Division--Most DD persons have few economic resources and thus are eligible for Medicaid and Supplemental Security Income. The Economic Assistance Division administers the Medicaid program which finances the medical needs of most DD persons both in institutions and in the community.

D. Rehabilitation Services Division--This division determines eligibility for Supplemental Security Income (SSI) payments. To be eligible for SSI payments, an individual must be 65 or older or blind or disabled and have limited income and resources. Another function of this division is to support the vocational rehabilitation services to some DD persons. In order to qualify for these services, the individual must demonstrate a reasonable capacity for competitive employment. Only a few DD persons qualify for vocational rehabilitation.

2. Department of Institutions.

The Department of Institutions maintains two institutions, Boulder River School and Hospital and Eastmont Human Services Center, for developmentally disabled individuals. As a result of deinstitutionalization, BRS&H has decreased in population from a high of nearly 1,000 residents to its current 225. Eastmont operates both a five-day program for school age children and a seven-day program for adults. Its current population is

about 50, 12 of whom are in the five-day program. Both of these facilities are licensed as Intermediate Care Facilities for Mentally Retarded (ICF/MR). In addition, BRS&H operates a 23 bed hospital to serve residents with severe medical problems. Residents at both institutions receive training daily.

In addition to the DD persons at Eastmont and BRS&H, there are 38 DD persons at Warm Springs/Galen State Hospital (some of these have problems in addition to being developmentally disabled).

3. Office of Public Instruction.

Montana school districts are required by law to provide special education services to DD students aged 6 through 18. Many school districts also offer schooling to DD persons aged 3 to 5 and 18 to 21. The Office of Public Instruction handles the administrative coordination and technical assistance for special education programs. Most of the cost of the special education programs (all of teacher's salaries, some of the supplies and materials, none of the heat and utilities) is paid by OPI.

4. Department of Health and Environmental Science.

The health department provides diagnostic evaluations and screening for handicapped children. Although this screening is not aimed primarily at DD children, many DD children have multiple handicaps and use this service. Some diagnosis and evaluation work is jointly funded by SRS, DHES, and OPI.

Problems with Administrative Structure

Since four state agencies provide services to DD individuals, some coordination problems do arise. Even within one department (SRS) there is sometimes a lack of clarity in the roles of the DDD regional staff (DD Division) and the social workers (Community Services Division). Specific problems include:

1. SRS and Department of Institutions compete against each other for money to serve the same type of people. Instead of working together to serve the DD population, each department has a tendency to fight for money for its own programs. With the present system, lack of movement from BRS&H (only one person has been placed this fiscal year) can easily be blamed on the other department.

Combining the functions of the DD Division and Department of Institutions (BRS&H and Eastmont) under one department might alleviate some of the problems, but also would present duplication of some administrative services. For example, the reimbursement bureau in the Department of Institutions handles reimbursements (private, insurance, medicare, medicaid) to all the institutions. This function would need to be duplicated in SRS if BRS&H and Eastmont were moved to SRS. Also, four divisions within SRS currently are involved in the DD community-based system. Thus, there cannot be a clear-cut system with SRS or the Department of Institutions exclusively handling <u>everything</u> related to DD persons.

Interviews with department heads indicate that nothing would be gained by combining functions of the two departments. SRS believes that as long as there are institutions, the functions of the two departments should remain separate. Similarly, the Department of Institutions believes that the present system works as well as any other system. Separation of the DD Division and the Department of Institutions seems to have caused more problems in the past. Both department directors agree that the system is functioning smoothly now.

2. There is sometimes a lack of clarity in the roles of the DDD regional staff (DD Division) and the social workers (Community Services Division). In general, the role of the social worker is at the client level

while the role of the regional staff is at the systems level. Sometimes, however, there is a fine line separating the roles.

Case management problems were described in Options for the Future, a study commissioned by DDPAC, as follows:

> "The case management system is rooted in two very different traditions: social work and DD services. The result is that there is not always a consistency or congruence between the two systems in terms of what should be done for DD persons, who should assume what responsibilities, or how these should be carried out.
>
> There is no central impetus for clarifying the various roles and responsibilities in the system, although there have been previous studies of the case management system and previous efforts to improve the relationships between the systems.
>
> There are some key roles within case management that are not being assumed by any part of the existing system, and this in turn is partly the result of the previous factors that have resulted in inadequately developed concepts of roles and conflicts about what should be done by whom.
>
> The problems are exacerbated by the fact that social workers are really county employees, and that many of their priorities are set at the county level regardless of what is promulgated by state level programs.
>
> There has been a very rapid growth in the community system, resulting in a rapid increase in the number of DD individuals that local social workers are responsible for serving, but there has not necessarily been a corresponding growth in the number of social workers, or in the level of expertise of those individuals expected to work with DD persons."

SRS has appointed a task force to determine whether the case management function should be assumed by the DD Division or remain with the Community Services Division. However, the problem remains of who sets priorities--state or local government.

Summary

Although four departments are involved in providing services to developmentally disabled persons, state officials feel only a few coordination problems exist. The Department of Institutions serves the DD

persons in Eastmont and BRS&H, while SRS provides services for DD persons in the community. OPI coordinates the special education programs in the schools and the Department of Health and Environmental Sciences provides some screening services.

Since the case managers of DD persons are county social workers, sometimes coordination problems exist between DD staff and social workers. Also, the social workers often have their priorities set by the county and not the state.

V. THE RELATIONSHIP OF NONPROFIT CORPORATIONS TO THE STATE

Most of the services provided to DD persons in the community are performed by private, nonprofit corporations. SRS contracts with these corporations to provide residential (group home and semi-independent living), day activity, transportation, family training, and respite services. Some corporations provide only one service (i.e. day activity), while others provide a combination of services. Most of the providers belong to the Association of Independent Disabilities Services (AIDS), an organization of Montana DD service providers.

Through the Community Services Division, SRS provides case management services to DD persons in the community. Each DD person who receives community services is assigned a case manager who is a county social worker. The case manager coordinates the IHP meetings and makes sure the services agreed to in the IHP are being provided. In addition to the case management services, SRS (through the Developmental Disabilities Division) monitors the contracts with the providers and offers training for the providers' staffs.

SRS and the nonprofit corporations view their relationship differently. The corporations believe SRS is purchasing a service and should contract to pay the provider a fixed amount. The providers should be accountable for the results ("Johnny can tie his shoe") which should be monitored by SRS. If the corporation does not spend all the contract money, the excess should remain with the corporation.

On the other hand, SRS believes the DD program has not been very accountable in the past. For example, some corporations have been able to accumulate large fund balances by saving part of their SSI money. The SSI money is supposed to be used for basic costs of living--food, shelter,

utilities, and basic clothing. In addition, SRS believes the Legislature has directed more fiscal accountability. The November special session of the Legislature passed HB 2 which directs providers to report financial transactions on a uniform accounting system. HB 2 states:

> "The department of social and rehabilitation services shall assure that the community developmental disabilities group homes are reporting all financial transactions through a uniform accounting system including a single chart of accounts and accounting manual.
>
> No money may be disbursed to the homes after July 1, 1982, unless the director of the department of social and rehabilitation services certifies to the legislative finance committee that the group homes are recording and reporting financial information uniformly."

During fiscal 1982, SRS will pay providers approximately $9 million. Although providers receive funds from other sources (private donations, local funds, SSI), their reason for being in existence is their contract with the state. Now that the economy is bad and the federal government is cutting back on funding, SRS wants to be able to defend its services to the Legislature. Also, with limited funding available, SRS would like to put the money where it is needed most.

In the area of fiscal accountability, SRS believes the providers should submit total budgets for approval by SRS and also should have major shifts of money between categories in the budget approved. The providers believe fiscal accountability is needed, but believe it should be handled differently. SRS should pay them a fixed fee per unit of service and providers would show (in detail) how the money was spent. Both SRS and the providers agree that some type of fiscal accountability is needed, but they do not agree on how it should be accomplished.

Interviews with providers pointed out several areas of concern over their relationship with SRS. These included SRS policies and administration, fund balances, contract monitoring, funding, and training. Each of these areas is discussed below.

SRS Policies and Administration

Some providers believe the DD Divison is trying to assume roles which should belong to the management within the provider corporations. Both SRS and providers feel local control is essential to community support for these programs. However, many providers view SRS's emphasis on accountability as a method of running the programs from Helena.

> "Under the guise of negotiating and monitoring contracts, DDD staff sometimes attempt to become involved in making management decisions such as how to schedule provider staff and establishing provider employee pay scales and benefits. Local boards of directors must be allowed to retain these functions if the current system is to be maintained. If the relationship between providers and SRS is to be a purchase of service agreement, roles should be clearly delineated. Management functions for provider corporations should belong solely to the corporation with checks and balances vested in the local boards of directors. The role of SRS should be limited to contract negotiation, monitoring/evaluation and long-range planning."

Providers are also frustrated by the changing policies within SRS and turnover in the position of DD division administrator.

> "Changes are too abrupt and are consequently disruptive, impossible and impractical at the local level. Providers are bombarded with changes every year at contracting time."

> "Often policies are made with little or no input from regional staff or local programs. This creates bad morale, mistrust and a lack of confidence."

"Each year the division pushes through a few more time consuming policies that waste time in the programs. The actual work done with the clients is reduced each year due to this fact. For example, the division recognizes only one type of training for the clients--Behavior Modification Programs. Consequently, their attitude is that the only legitimate kind of training is based on that model. The reason for this is that behavior modification programs can be measured in terms of numbers."

"Nearly annual turnover in this top-level position has produced a situation where leadership within DDD is constantly having to be re-educated about the system and its problems. Administrative consistency has been lacking due to leadership turnover as well as to the fact that other DDD staff do not have a broad understanding of community-based services to appropriately assist in the re-education process."

SRS agrees that local control is important. Locally run corporations encourage meaningful grass roots support. However, SRS believes that providers have enjoyed a lack of accountability for a number of years and some changes are needed. Because of federal cutbacks and a limited amount of state money, SRS feels it needs to do more to justify its programs to the Legislature. Thus, SRS wants the providers to be more fiscally and programmatically accountable to SRS.

Provider Fund Balances

Many nonprofit corporations are accumulating fund balances of substantial amounts. Funds from the DD Division are strictly accounted for and money not spent at the end of the year is returned, but funds from other sources (SSI, production, vocational rehabilitation, private donations, etc.) are not. Some corporations report modest fund balances (under $20,000), but others have fund balances of more than $100,000. Providers expressed the following reasons to accumulate a fund balance:

- Increase services.
- Accrue vacation and sick time for those employees whose positions are such that substitute help is mandatory when these employees take sick or vacation leave.

- Remodel.
- Fund unanticipated major repairs.
- Replace van.
- Purchase items which may be unallowable through standard contracts or for which funds were just not available.
- "Fund essential projects which either would not happen if we depended on DDD completely for money or they would have cost much more in interest."

The providers think having a fund balance is the fiscally responsible way to run a business. One provider says:

> "My feeling is that the people who control various parts of this DD system should be delighted that some DD providers have the initiative, entreprenurial capability and luck to be able to provide quality services and make a profit. The projects the fund balance money has been spent on are projects which enhance the lives of DD people and enhance our ability to respond to individual needs. They are projects which in several cases have saved the system considerable money, but would not have been possible if we did not have that fund balance. For example, the insulation of the ceiling of the shop will be amortized in 3½ years and in 5 years will save us and funding sources and therefore taxpayers about $50,000. None of our funding sources have any means by which a project such as insulation could be financed."

SRS allows the nonprofit corporations to accumulate fund balances from sources other than state funds. However, SRS believes it should be notified as to how much the fund balance is. The reason for this is that there is a limited amount of money available. While SRS does not propose to reduce the contract funds of a provider who has a fund balance, SRS does believe the status of a fund balance is relevant when a corporation asks for a budget amendment. For example, if a corporation asks for a budget amendment for unanticipated major repairs, SRS wants to be able to determine the financial need of that corporation. With limited funds available, SRS would like to be able to take care of the budget amendment requests from those providers who have no other source of income.

Contract Monitoring

The providers believe contract monitoring should be more consistent and less process-oriented.

> "I feel that the quarterly progress reports of provider accomplishment of contract objectives are exceedingly important and should be verified for accuracy by random checks of data according to uniform procedures used statewide. Contract evaluation/monitoring procedures generally seem inconsistent and arbitrary. Procedures and standards vary widely from region to region and within regions from one provider to another."

In addition to being more consistent, providers would like to see the monitoring more result-oriented than process-oriented. For example, one provider cited a case where he was graded down for not placing his initials in the correct spot. Thus, providers believe the focus of the evaluations should change from process to results.

SRS agrees that contract monitoring is sometimes inconsistent. Currently, SRS is using a point system to evaluate providers. Beginning next fiscal year, SRS will change to a narrative type of evaluation. A sample of IHPs will be looked at and a narrative report giving observations and recommendations will be written. SRS realizes that inconsistencies in evaluations exist between regions. They hope that the new type of evaluation will minimize these inconsistencies.

Funding

The providers would like SRS to pay a uniform fee by speciality area, modified as necessary by client severity level. For example, a group home would be paid a set amount based on the number of clients served. As long as it meets a minimum number of people served and meets the contract objectives, the provider would receive the money with no strings attached.

Lack of money is also a problem with providers. Providers believe more money is needed for preventive maintenance of facilities and for salaries to group home staff. Providers believe the pay scales to group home trainers is inadequate and results in a high level of staff turnover. One corporation reports being able to pay group home managers only $4.56/hour and group home trainers $4.06/hour after one year; the starting salary is $3.55/hour with no benefits. Some corporations are able to pay more because the budgets are calculated incrementally (i.e., applying a percentage increase to the current level). .

SRS agrees that some type of uniform funding could be considered in the future. However, the idea is premature at this point. For example, if uniform funding is to be affected by client severity level, a uniform assessment tool is first needed to measure the client severity level. Currently each provider uses his own assessment tool.

Before using a uniform funding structure, SRS wants to examine the services which are being purchased. For example, SRS believes it is purchasing more than room and board in a group home--it is also purchasing a certain amount of training for each DD person. How much training is involved varies with the group home. To compensate providers uniformly would require that providers give similar services. If a limited amount of money is available, some providers might receive less money under uniform funding than they do now.

Training

Through its regional staff, the DD Division provides training for the providers' staffs. Some providers believe the training is not effective. One provider mentioned that its staff turnover is so high that the training offered by SRS is ineffective due to the length of time required for the training.

"Close scrutiny needs to be made regarding whether the training supplied by DDD is cost-effective and should be maintained. Based on the experience of a group home staffing model used by this corporation in FY'82, it is my belief that other training models should be explored. Training monies should be invested primarily in local corporations to assure well-trained provider staffs locally with technical assistance and delivery of training available from DDD."

The training (DDCPT) offered by the DD Division takes 80 hours. Since most providers cannot give their staff a continuous block of 80 hours time, the DD trainers work with the providers to schedule training. Generally the training takes place over a six month to one year period of time.

Summary

Although several problems were cited by providers, the major problem seems to be a difference in philosophies: the providers want to be independent and want SRS to delegate more responsibility for the DD clients; SRS wants the providers to be more fiscally and programmatically accountable to SRS.

VI. OTHER PROBLEMS

Previous sections of this report have mentioned problems in the DD system related to the need for services, relationship between SRS and the nonprofit provider corporations, the state administrative structure, and the cost of services. This section addresses other problems in the DD system. Specific problems which are discussed are the following:

1. No incentive for client movement through the system.
2. No long range planning for maintenance of group homes.
3. Problems with medical care.
4. Lack of planning for older DD persons.
5. Lack of planning for the future of special education students.
6. New federal regulations for special education.
7. Changes in eligibility requirements for SSI.

Identification of these problems and related comments came from discussions with SRS, providers, and social workers. A writeup of each problem follows.

Incentive for Client Movement

There is no incentive for client movement through the system. This problem exists in both day programs and in group homes. When a DD person is a good worker in a work setting (especially a production setting), the provider has no incentive to try to move the client to a competitive work situation. Not only would the provider lose a good producer, but the replacement for that producer would probably be someone much less skilled. Also, if a DD person tries competitive employment and does not succeed, he might be worse off as the day program usually holds his slot

for only 30 days and he risks losing his SSI payments when he holds a competitive job.

Similarly, in a group home, the provider has little incentive to move out a well-behaved higher functioning person when the replacement might be a low functioning person with behavior problems at no extra compensation.

SRS says they recognize this problem and are addressing it by putting goals in the contract to move a certain number of persons through each year. Thus, the providers would be required to move people each year. SRS has also started a pilot program in Billings to help the movement problem. This program finds competitive jobs for DD persons, works with the employer to train the employee, and provides follow up for more than the regular 30 day follow up period.

Group Home Maintenance

There is no long range plan for maintaining and upgrading group homes. Although SRS's budget request for the 1981 Legislature included funds to begin making improvement to the group homes, this request was not part of the governor's recommended budget. The housing supplement to Options for the Future states:

> "4.8 Use for Existing Community Homes. The recent survey of ten community homes by the Department of Social and Rehabilitation Services found that on the average, these ten randomly selected homes needed improvements amounting to $16,689. This included $5,820 for repairs to make the homes accessible to the physically handicapped; $8,691 for basic repairs to the structures and $2,178 for improvements needed to make the homes more energy-efficient.
>
> If these ten group homes are typical of the total 51 adult group homes currently in operation in the state, there is a need for approximately $850,000 worth of repairs to group homes over the state."

Maintenance of group homes is important because lack of maintenance on present homes may affect the willingness of neighborhoods to accept group homes in the future.

Medical Services

Medical services are sometimes used inappropriately. Two problems need to addressed in this area:

1. Sometimes DD persons are required to attend day activities when they are ill, because the group home is closed during the day. Currently, there is little flexibility to allow a DD persons to stay at home during the day unless he is extremely ill. When this happens, the provider corporation must keep an employee in the home also.
2. Sometimes DD persons visit the doctor more often than necessary and thus waste medicaid dollars. Since no one wants to be liable if a cold turns into pneumonia, many times DD persons are taken to the doctor before it is necessary. In addition, some DD persons living semi-independently use medical resources inappropriately. For example, one DD person went to the emergency room for a stomach ache; another called an ambulance to take him to the doctor because he liked to ride in ambulances.

Older DD Persons

Until recently, all DD persons who lived in group homes were required to participate in vocational training. For DD persons of retirement age, this training was not always appropriate. Now three day programs have been started for elderly DD persons. However, no allowance has been made for an elderly DD person to stay at home if he does not feel like going to the day program on a particular day. When most people retire,

they are allowed to sit at home if they wish. On the other hand, elderly DD persons are required to attend day activities. As more DD persons reach retirement age, this will become a greater problem.

Special Education

Some special education students are not placed on appropriate waiting lists early enough. When students graduate from the special education program in the schools, they usually need some type of service from the DD Division. Some of these persons may continue to live at home and need only day services, such as a work activity center or a sheltered workshop; others may require group home, transportation, and day services. Since the average length of time on the DD waiting list is 12 months, it is important that DD students are known to the system before they graduate. However, schools are required to keep information on these students confidential.

Each spring the DD Division contacts the schools and asks them to explain the situation to the parents of the DD students. The parents are requested to contact the DDD regional office to put their children on waiting lists for specific services. However, some students slip through this process and thus are not placed on appropriate waiting lists. This problem can seriously impair the long range planning function in the DD Division.

Reduced Special Education Services

New federal regulations may decrease the services schools are required to offer to handicapped children. By law, all children are entitled to a free and appropriate public education. Developmentally disabled children are served through the special education program. The federal Department

of Education is currently discussing altering the present regulations to require fewer services to be offered by school districts. However, the Department of Education would still require the states to provide the services. Services which might be affected include physical therapy, hearing aid and glasses. Since many mentally retarded children are multiple handicapped, the new regulations may affect state budgets other than OPI's. The new regulations will be released later this month.

The new regulations may also be more specific about the definition of "appropriate." Recently in Pennsylvania, it was decided that for one student, "appropriate" meant year round education. Since other students get only nine months of schooling, there is some controversy about this student getting more than others.

Since the new regulations have not been released yet, it is difficult to speculate how the changes will affect the DD system in Montana. If school systems are not required to provide certain services, the services may need to be funded by another state agency.

Possible SSI Change

Changes in the eligibility requirements for SSI may exclude some DD persons from receiving SSI benefits. Currently, DD persons in group homes receive $264.70 per month in SSI benefits and $104 in state SSI supplement. DD persons receive SSI payments based on their disability (mental retardation). However, changes in the definition of disability may reduce the number of DD persons eligible for SSI. Congress has directed the Social Security Administration to review 100 percent of the disability claims by July 1983. Higher functioning DD persons and those who have held jobs might no longer be eligible to receive SSI payments. SRS is aware of this problem and is currently studying the situation.

Summary

Other than the problems discussed in earlier sections, six areas of concern were mentioned during discussions with providers, SRS and social workers. These concerns address the areas of client movement, maintenance of group homes, medical care, older DD persons, special education, and SSI.

Options for the Future, a study commissioned by DDPAC, more comprehensively examines some of these problems. The state needs to set priorities to address solutions. In some cases (i.e., maintenance of group homes), more money will be needed. Other problems (i.e., medical care) perhaps can be solved by suitable training.

VII. SUMMARY

As a result of HJR 26, the Legislative Finance Committee is studying the services to developmentally disabled (DD) persons. Both institutional and community services have been reviewed. This report examines the effectiveness of the DD system, need for DD services, cost of DD services, state administrative structure, relationship of nonprofit provider corporations to the state, and problems in the present system.

Effectiveness of the DD System

This report looks at effectiveness in terms of the legal mandate which refers to habilitation in the least restrictive environment. To measure effectiveness, the report discusses movement through the system--both movement from institutions and movement within community services.

Since April 1975, 307 persons have moved from BRS&H to community services. Only one of those moved this fiscal year. Within community services, 64 persons moved out of group homes from July 1980 to December 1981. Fifteen of those moved to semi-independent living, 10 to family homes, 6 to foster homes, 19 to nursing homes, and 19 to other places.

Another measurement of effectiveness is the change in quality of life of the DD person. Areas which may be examined are level of dependency, vocational achievements, social interaction, academic achievements, personality growth and community integration. Providers, representatives of SRS and the institutions, family members of DD persons, and other interested persons have been invited to testify on the effectiveness of the DD system.

Need for DD Services

The report looks at need in terms of number of DD services being offered and number of DD services on the waiting list. Currently 3,291

service slots are being used and 1,020 are on an unduplicated waiting list. In addition, 217 service slots will be needed for special education graduates in 1983 and 1984. The above numbers do not reflect the DD persons who could be moved from the institutions to the community or the unidentified DD persons.

Cost of Services

The cost of community services was calculated from the provider survey responses and from the other costs: Medicaid, special education, social workers, and DD Division administration costs. For an adult living in a group home, an average cost was calculated as shown in the following table.

Cost of Community Services for DD Adult in Group Home
Fiscal 1981

Type of Service	Cost
Group Home	$ 7,793
Transportation	660
Day Service	6,140
Medicaid	2,700
Case Management	563
DDD Administration	677
Total Cost	$18,533

All sources of funds were included--DDD contract, SSI, food stamps, low income energy assistance program, commodities, local funds, production income, and miscellaneous funds. Using a similar analysis, the cost of providing services for a child in a group home in fiscal 1981 was $23,967.

Institutional costs were calculated for BRS&H and for the seven-day program at Eastmont. The costs at BRS&H were calculated by looking at the entire operating budget and subtracting reimbursements from private payments and insurance. Eastmont costs were calculated using the Medicaid reimbursement rate and adding back in an average cost for the services not reimbursed by Medicaid. The cost per resident at BRS&H was $38,524 in fiscal 1981, while the cost per resident at Eastmont was $24,632. The Eastmont cost does not include the cost of medical treatment, and the BRS&H cost may not be inclusive of all medical costs.

State Administrative Structure

Four departments provide services to DD persons: the Department of Institutions, SRS, Office of Public Instruction, and Department of Health and Environmental Science. Within SRS, four divisions provide services: Developmental Disabilities Division, Community Services Division, Rehabilitation Services Division and Economic Assistance Division.

In the past, coordination problems have existed between the Department of Institutions and SRS. Now, however, both departments believe the present system is working smoothly. Problems are present in determining the role of the social worker and the DDD regional staff. Social workers sometimes have their priorities set by the counties rather than the state.

Relationship of Nonprofit Corporations to the State

The DD Division contracts with private nonprofit corporations to provide services to DD persons in the community. The DD Division monitors the contracts and provides training to the providers' staffs. Providers identified problems in four areas: SRS policies and administration, fund

balances, contract monitoring, funding and training. A major problem stems from the difference in philosophies between SRS and the providers. Because of the limited money available, SRS wants the providers to be fiscally and programmatically accountable to SRS. The providers think they are accountable and see this as SRS wanting to control their corporations.

Other Problems

Seven problems in other areas were also identified: These are as follows:

1. No incentive for client movement through the system.
2. No long range planning for maintenance of group homes.
3. Problems with medical care.
4. Lack of planning for older DD persons.
5. Lack of planning for the future of special education students.
6. New federal regulations for special education.
7. Changes in eligibility requirements for SSI.

In some cases (i.e., maintenance of group homes), more money may be needed. Other problems (i.e., medical care) may be solved by suitable training.

VIII. COMMITTEE CONCLUSIONS

After hearing testimony from parents of DD persons, SRS, and DD providers, the committee agreed that the community DD system is successful. However, problems do exist between SRS and the DD providers.

Effectiveness of Services

The community DD system is effective. Significant positive results have occurred in less restrictive environments which respect the individual's personal dignity in the community DD system. However, some DD persons have intensive medical and training needs, and with the present facilities available, may be better served in an institution. For the DD system to remain functional and effective, the relationship between SRS and the providers must be improved.

Need for Services

There is a need for more community DD services as shown by the unduplicated waiting list. Four types of persons need the expanded services:

1. Persons in the community who are presently receiving services.
2. Persons in the community who are not receiving services.
3. Persons in the institutions who are ready to move to existing services in the community.
4. Persons in the institutions who could move to the community if intensive services were available.

Cost of Services

The service cost was less expensive for those DD persons presently in the community. The cost figures presented in the report represent

average costs for each service. If more DD persons are moved from Boulder River School and Hospital and Eastmont, the following factors will affect the overall cost:

1. Most of the residents in institutions have more intensive needs than the DD persons currently in the community. An institutionalized DD person may need the same number of service slots as someone in the community, but his service slots will be more intensive and therefore more expensive.

2. If a resident leaves the institution, the total cost of running the institution will not decrease by the average cost per resident.

3. As new facilities are acquired to accommodate more DD persons in the community, the costs increase. A group home purchased in 1982 is subject to much higher interest rates than one purchased in 1974. Thus, the cost of expanding housing slots for placing a DD person into community services is not merely the average historical cost.

The Legislative Fiscal Analyst staff will develop cost comparisons for Boulder River School & Hospital and intensive care homes during their budget analysis.

State Administrative Structure

The present state administrative structure of four agencies is adequate. The problems identified with county social workers are being addressed by SRS. A task force to study these problems was set up in the spring. Their report is attached as Appendix B.

The Relationship of Nonprofit Corporations to the State

The relationship between DD providers and SRS has many problems. The underlying problem is a difference in philosophies: the providers want more autonomy and flexibility in their operation, while SRS wants more accountability by the providers.

A task force has been established to try to resolve the problems. The task force is composed of representatives from SRS, the providers and the public. The Legislative Finance Committee will monitor the progress of this task force.

The committee has directed the Legislative Fiscal Analyst to review SRS's financial information needs for DD providers and the ability of DD providers to report this data to SRS.

Other Problems

Seven other problems were noted in the report. A letter has been sent to the Department of Social and Rehabilitative Services and the Association of Independent Disabilities Services identifying the problems and stating the committee's concern. To solve some of the problems, additional funding may be needed. This will be addressed in the fall budget cycle. Other problems, such as the activity needs of elderly DD persons, inappropriate use of medical care by DD persons, and incentives for client movement, may be solved by planning and management. The Legislative Finance Committee urged the Department of Social and Rehabilitative Services to do more planning and management to solve this problem.

TESTIMONY FROM THE HEARING ON
HOUSE JOINT RESOLUTION 26
July 22, 1982

TOM HANNAH, Advisory Board, Special Training for Exceptional People (Billings)

Mr. Hannah said the key issue is the relationship between SRS and the providers. This is the central problem which needs to be addressed by the committee. He then reviewed the legislative history and intent of the nonprofit services. The 1973 Legislature passed the Community Services Act, whereby services could be provided in the community. However, this bill was not funded. In 1975, modifications were made and the bill was funded. The Legislature wanted nonprofit corporations, not extensions of the state.

VONNIE KOENIG, Parent (Kalispell)

Ms. Koenig described her 22 year old son who has an IQ of 25. He graduated from special education in June and will attend the Flathead Industries day program in August. He has been on the waiting list for two years. The reason he can go from special education directly into community services is because the expansion money funded additional service slots.

Ms. Koenig also addressed the issue of effectiveness of DD community services. She believes noticeable improvements have occured in DD individuals in her community. As a parent, she is not interested in the turfdom problems, but wants quality services provided.

LORI MEHRER, Board Member, MDDCHC (Missoula); Special Education Teacher

Ms. Mehrer testified that only a locally controlled situation can provide the most cost-effective and best situation for clients. Only on the local level can appropriate planning and appropriate care come about. Local control allows for client movement and for the needs of the community to be considered. Other communities may have needs different from those of her community.

Ms. Mehrer also spoke on the effectiveness of the community program. She is a former employee at BRS&H and she believes that former residents of BRS&H are more active and involved in the community.

GREG MUNROE, Chairman of Board, Billings Workshop, Inc.

Mr. Munroe believes the principle problem in the DD system is the relationship between SRS and the providers. His corporation contracts with organizations other than the DD Division, including private companies and the Rehabilitative Services Division in SRS. Only 33 percent of their funding comes from the DD Division. They have not signed their contract with the DD Division this year because they can't agree on the relationship question.

Mr. Munroe presented a comparison of contracts with the DD Division since 1974. He described how much more control the state has gotten over the past years. For example, in 1975, the providers maintained autonomy and control over the eligible clients. Now the process includes a detailed IHP process, individual program plans, and 13 pages of how to conduct skill acquisition, skill acceleration, generalizations and behavior deceleration. The state is telling them exactly how to run programs.

On the question of fund balances, Mr. Munroe stated that fund balances are often related to the size of the corporation. They are a large corporation and they do have a fund balance. However, the fund balance doesn't come from their contract with the DD Division, but from their contracts with the private sector.

Mr. Munroe also addressed the problem of SRS policies. The fiscal 1983 contract states that providers must comply with all SRS policies, even those that were not yet in effect on the date of signing the contract. Later in the testimony, it was pointed out that the contract also states if the new policies have a financial impact, the contract could be renegotiated. Mr. Munroe acknowledged that many of the new SRS policies are "pass-throughs", policies which SRS is required by state or federal law to implement.

Mr. Munroe believes the community DD program is an outstanding success. The clients go to work every day, which is much better than sitting in an institution.

JOHN LAFAVER, Director, Department of Social and Rehabilitation Services

Mr. LaFaver testified that we need to ensure, at the state and local level, that services are provided in a cost-effective way which is in harmony with the community and which engenders community support. The state has been increasing control. In 1976 there was a demand to get people out of the institution and into the community. It was done in a hurry and a lot of money was spent. Some very serious errors occurred as a result of the rush. Although the advantages outweigh the disadvantages, some major errors did occur.

Mr. LaFaver described some of the problems he sees every day--problems which lead him to believe that the ultimate responsibility lies with SRS. These problems include the following:

1. The wide disparities of wage levels among corporations. Legislators and others have called to ask Mr. LaFaver what he will do about this.

2. Establishment of group homes. Two situations have occurred in the past 18 months where a corporation started a new group home without "doing its homework". The community was not prepared for the group home and residents complained to the Governor. SRS had to go out and do the homework for the corporation.

3. Maintenance of group homes. Recently, Mr. LaFaver received a letter from a Legislator complaining that the group home across the street from him was not being maintained.

4. Collapse of a provider corporation. Who takes care of the clients?

These problems illustrate that the public believes the state is ultimately responsible for the DD program.

Mr. LaFaver believes the strength of the DD program very often is in the local corporations. The state needs to encourage initiative and not bury the providers in red tape. New policies and tightening contract provisions are in response to at least one problem at a local level that SRS wanted to solve before it became a problem.

KATHERINE KELKER, Chairman of Board, STEP (Billings)

Ms. Kelker described the community support received by her corporation. The members on her board bring in an expertise in business, management, and special education. The corporation receives much volunteer help and many donations from the community--the Naval Reserve does maintenance on the group homes and the Foster Grandparents visit with the clients.

Ms. Kelker discussed the role of SRS and the providers. She believes the role of SRS should be that of a funding source and a program monitor. The corporation should know in advance who will monitor what and with what standards. National standards should be used by a trained monitoring team. A monitoring team similar to the one used by OPI to monitor special education programs could be used. Her corporation would welcome constructive monitoring, but the monitoring by the DD Division has been so unsystematic, it is hard to know where they stand.

BILL CRIVELLO, Executive Director, Flathead Industries (Kalispell)

Mr. Crivello also testified on the level of control by SRS. Many of the SRS policies are constrictive and are not effective. Other funding sources, such as the Rehabilitation Services Division, do not have such constrictive policies. The Legislature and SRS need fiscal and programmatic accountability; the providers need to be independently capable of managing their corporations. However, the answer to accountability is not control. The providers want minimum control and maximum flexibility, and they will try to agree on mutual standards and mutual measures of effectiveness.

The community DD program is effective. The nonprofit corporations are involved directly in the community. We need to continue support of the nonprofit corporations and build even more support within the community, while maintaining high goals and allowing individual programs to be flexible. There must be adequate provision for each program to develop appropriate services for the needs of its clients in its community. This must be done with state support--the providers can't do it alone.

LORRI HEFINEIDER, Residential Support Services (Billings)

Ms. Hefineider discussed the funding of group homes and the need to upgrade salaries and benefits for direct care staff. They have a high turnover rate because of the low salaries and benefits. The highest paid person in their group homes is paid $9,500.

JOE ROBERTS, concerned individual

Mr. Roberts stated that the relationship between SRS and the providers is not the only problem in the DD system. The waiting list indicates that a lot more DD persons need services, including 11 people in institutions who could move to the community. Also, incentives need to be built into the system to move people through all levels.

PATRICIA CARRICK, Dillon Special Resources (Dillon)

Ms. Carrick testified that there is a philosophical difference between the providers and the DD Division. She believes the providers should be responsible for internal management, their independently earned funds, and decision-making regarding corporate operations. The providers and the DD Division are polarized; there is suspicion, mistrust and a lack of good faith between the two. Perhaps a mediating entity could help work out the differences.

COMMITTEE DISCUSSION

The finance committee discussed the language on SRS policies in the contract. Some committee members believe the new language is unfair; the rules should not be able to be changed in the middle of the game. Other committee members felt the contract was worded so that providers could renegotiate if new policies imposed a hardship. The specific wording of the contract is:

"38.0 COMPLIANCE WITH APPLICABLE LAWS, RULES AND POLICIES

37.1 LAWS

Provider will comply with all applicable state, federal, and local laws in performing this contract.

38.2 Rules/Regulations

Provider will comply with all applicable state rules and federal regulations in performing this contract. In particular, Provider will comply with the requirements of 45 CFR, Part 96.30 and all regulations referenced therein.

38.3 Department Policies

Provider will comply with all official Department Policies relating to Developmental Disabilities.

38.4 Changes in Laws, Regulations or Policies

This contract is subject to renegotiation at Providers request for the purpose of enabling Provider to comply with new laws, regulations, or Department Policies if changes/additions materially affect the ability of the Provider to perform the terms and conditions of this contract as written."

JOHN FILZ, President, Association of Independent Disabilities Services

Mr. Filz believes the heart of the issue is not the policy problem but the overall relationship problem. He stated that providers want both program and fiscal accountability. Providing that corporations retain the autonomy to determine where and how the funds are spent within the parameters of state and federal law, the providers encourage SRS to audit all their sources of funds. In the area of fund balances, Mr. Filz believes the state should encourage the system to generate financially sound, healthy corporations, because financially sound, healthy corporations with reserves, good management experience, and the ability to handle money are going to survive when the dollars decrease. Programs that zero out and operate as state agencies are going to die when the dollars decrease.

CHARLOTT HAUGHIAN, Parent (Miles City)

Ms. Haughian asked the committee not to lose sight of whom the money is for--the DD clients. She testified her daughter is improving continuously due to community DD programs.

PW:rc:a

APPENDIX B

Report of Case Management Task Force on County Social Workers

Originally scheduled for completion by early November, this report is still not available on December 14.

APPENDIX C

Members of the Developmental Disabilities
Contract Advisory Council

Name	Title	Affiliation
Bill Crivello Flathead Industries 305 - 3rd Ave. East Kalispell, MT 59443	Director	Provider
Gary Pagnotta Reach Inc. Box 1944 Bozeman, MT 59715	Director	Provider
Mike Morris Comprehensive Development Center T-125 Fort Missoula, MT 59801	Director	Provider
Gary Marbut 7500 Lime Springs Tr. Missoula, MT 59812		DDPAC
Chuck Super Regional Services for the Disabled P.O. Box 31253 Billings, MT 59107	Director	Provider
Wally Melcher Region II Child and Family Services 1500-9th Avenue South Great Falls, MT 59405	Director	Provider
Peter Blouke Department of Institutions Helena, MT 59620		Dept. of Institutions
Larry Fasbender Box 23 Fort Shaw, MT 59443		Ex-Legislator
Jack Ellery Developmental Disabilities Division Department of SRS Helena, MT 59620	Administrator	SRS

Mike Muskiewicz Planning Assistance and Management Bureau Department of SRS Helena, MT 59620	Chief	SRS
Jim Meldrum Developmental Disabilities Division Department of SRS Helena, MT 59620	Assistant Administrator	SRS

August 25, 1982

Mr. John D. LaFaver, Director
Department of Social and Rehabilitation Services
Helena, MT 59620

Dear John:

Our review of DD services has shown that the community DD system is very effective. However, a few areas of concern do exist. We understand that SRS is addressing some of these problems now, and we hope that continued attention to these problems will result in many of the problems being resolved.

The public testimony at the July Legislative Finance Committee meeting mainly addressed problems in the relationship between SRS and DD providers. We have instructed staff to monitor the task force which has been established to solve difficulties in the relationship. Our staff will also be reviewing state financial information needs to determine what information DD providers should report routinely to SRS.

In addition to the problem of relationship, a number of other problems exist in the DD system. These include:

1. No incentive for client movement through the system.
2. No long-range planning for maintenance of group homes.
3. Problems with medical care.
4. Lack of planning for older DD persons.
5. Lack of planning for the future of special education students.
6. New federal regulations for special education.
7. Changes in eligibility requirements for SSI.

These problems are discussed in more detail on pages 43 to 48 of the report prepared for House Joint Resolution 26. We urge SRS to work on these problems. Most of these problems may be solved by planning and management.

The community DD system has been very successful. We hope that attention to the above problems will increase its success.

Sincerely,

Senator Ed B. Smith, Chairman
Legislative Finance Committee

cc: John Filz, President
Assoc. of Independent Disability Services

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